ATTACHMENT VII - INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

INSTRUCTIONS FOR COMPLETING THE HYSTERECTOMY ACKNOWLEDGMENT FORM

Always Complete This Section

1. Enrollee Name: Enrollee's Name can be typed or handwritten. Must be completed.

2. TennCare ID No.: Enrollee's TennCare Number can be typed or handwritten. Must be completed.

3. Physician's Name: Physician's Name can be typed or handwritten. Must be completed.

4. Date of Hysterectomy: Date the hysterectomy was performed. This can be typed or handwritten. Must be completed.

Section A: Complete This Section For Enrollee Who Acknowledges Receipt Prior To Hysterectomy

5. Witness Signature Date: Witness must sign his/her name an date simultaneously in his/her own handwriting prior to surgery.

6. Patient's Signature/Date: Patient must sign her name and date in her own handwriting simultaneously prior to surgery. (If the patient cannot sign her name she can make her mark "X" in patient's signature blank if there is a witness. The witness must sign down below his/her name and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness' own handwriting. The witness should write witness beside their name.

If Section A is completed, STOP HERE.

Section B: Complete This Section When Any Of The Exceptions Listed Below Is Applicable

7. Retroactive Eligible Enrollee Only: This box is checked only if the enrollee was approved retroactively. A copy of the TennCare card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

8. This box is checked if the patient was already sterile prior to surgery. Describe cause of sterility. This can be typed or handwritten.

9. This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. Describe the emergency situation. This can be typed or handwritten.

10. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.

Section C: Complete This Section For Mentally – Incompetent Enrollee

11. Witness Signature/Date: Witness must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

12. Patient Representative Signature/Date: Patient representative must sign his/her name and date simultaneously in his/her own handwriting prior to surgery.

13. Reason For Hysterectomy: Describe the reason for the hysterectomy. This may be typed or handwritten.

14. Physician's Signature/Date: The physician must sign his/her name and date simultaneously in his/her own handwriting after surgery.

MEDICAID - TITLE XIX
ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

➔ALWAYS COMPLETE THIS SECTION←

Recipient Name _____ Medicaid ID No. _____

Physician's Name _____ Date of Hysterectomy _____

➔COMPLETE ONLY ONE OF REMAINING SECTIONS: COMPLETE ALL BLANKS IN THAT SECTION←

SECTION A: COMPLETE THIS SECTION FOR RECIPIENT WHO ACKNOWLEDGES RECEIPT PRIOR TO HYSTERECTOMY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on me it will render me permanently incapable of reproducing.

WITNESS' SIGNATURE _____ DATE _____ PATIENT'S SIGNATURE _____ DATE _____

SECTION B: COMPLETE THIS SECTION WHEN ANY OF THE EXCEPTIONS LISTED BELOW IS APPLICABLE

I certify that before I performed the hysterectomy procedure on the recipient listed below:

CHECK ONE

1 ☐ I informed her that this operation would make her permanently incapable of reproducing. (**This certification for retroactively eligible recipient only** - a copy of the Medicaid card which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before the reimbursement can be made)

2 ☐ She was already sterile due to _____

CAUSE OF STERILITY

3 ☐ She had a hysterectomy performed because of a life-threatening situation due to _____

DESCRIBE EMERGENCY SITUATION

and the information concerning sterility could not be given prior to the hysterectomy.

PHYSICIAN'S SIGNATURE _____ DATE _____

SECTION C: COMPLETE THIS SECTION FOR MENTALLY-INCOMPETENT RECIPIENT ONLY

I acknowledge receipt of information, both orally and in writing, prior to the hysterectomy's being performed, that if a hysterectomy is performed on the above recipient, it will render her permanently incapable of reproducing.

WITNESS' SIGNATURE _____ DATE _____ PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____

PHYSICIAN'S STATEMENT

I affirm that the hysterectomy I performed on the above recipient was medically necessary due to _____

REASON FOR HYSTERECTOMY

and was not done for sterilization purposes, and that to the best of my knowledge the individual on whom the hysterectomy was performed is mentally incompetent. Before I performed the hysterectomy on her I counseled her representative, orally and in writing, that the hysterectomy would render that individual permanently incapable of reproducing; and, the individual's representative has signed a written acknowledgment of receipt of the foregoing information.

PHYSICIAN'S SIGNATURE _____ DATE _____

Attach a copy to claim form when submitting for payment. Provide copies for patient and for your files. ADDITIONAL DOCUMENTATION MAY BE REQUESTED BEFORE PAYMENT IS MADE.

THIS FORM MAY BE REPRODUCED LOCALLY